FAX or EMAIL PATIENT STICKER

SUBJECT: COVID-19 Monoclonal Antibody Infusion Order
TO: Comanche County Memorial Hospital Infusion Services
FAX: (580) 585-5472
ADDRESS: 3126 NW Arlington Blvd Lawton, OK 73505
EMAIL: infusion@ccmhhealth.com
PHONE: (580) 355-8699 Option 1, Ext 4756 or Ext. 6194 for Scheduling

FORMS MUST BE COMPLETE (NO BLANKS) AND SIGNED BY THE PROVIDER FOR THE PATIENT TO BE CONSIDERED FOR Monoclonal Antibody Infusion

PLEASE PRINT

DATE:_____ **VACCINATION STATUS:**_____
PATIENT NAME:_____ **DOB:**_____
PHONE:_____ **HEIGHT (inches):**_____**INCHES** **WEIGHT:**_____**KG (at least 40kg)**
ALLERGIES:_____
DIAGNOSIS CODE:_____ **DIAGNOSIS NAME (REQUIRED)**_____
PROVIDER NAME (PRINT LAST & FIRST):_____
PROVIDER OFFICE PHONE#_____ **OFFICE FAX #**_____
CONTACT PERSON AT PROVIDER OFFICE:_____

SARS-CoV-2 Specific Monoclonal Antibody Guidelines

● CCMH SARS-CoV-2 Specific Monoclonal Antibody Guidelines available in CCMH COVID Toolkit.
● Casirivimab/imdevimab, bamlanivimab/etesevimab and Sotrovimab are investigational drugs and are not currently FDA approved for any indication.
● The FDA issued Emergency Use Authorization (EUA) to authorize the emergency use of casirivimab/imdevimab or bamlanivimab/etesevimab and Sotrovimab for the treatment of mild to moderate COVID-19 with positive results of direct SARS-CoV-2 viral testing who are at high risk for progressing to severe COVID-19 and/or hospitalization.

EUA provider fact sheets:

Sotrovimab EUA provider fact sheet available at https://www.fda.gov/media/149533/download
Casirivimab and imdevimab EUA provider fact sheet available at Https://www.fda.gov/media/143892/download
Bamlanivimab and etesevimab EUA provider fact sheet available at: https://www.fda.gov/media/145802/download
Remdesivir provider fact sheet available at (Outpatient use is Off-Label, but currently recommended by NIH):
https://www.gilead.com/-/media/files/pdfs/medicines/COVID-19/veklury/veklury_pi.pdf
NIH guidance on Therapies for High-Risk, Nonhospitalized Patients With Mild to Moderate COVID-19 available at:
https://www.covid19treatmentguidelines.nih.gov/therapies/statement-on-therapies-for-high-risk-nonhospitalized-patients/

SARS-CoV-2 Specific Monoclonal Antibody CRITERIA FOR USE

☐ Symptom Onset Date: _____Positive COVID-19 test date_____ OR exposure date_____

Patients must meet **ALL** criteria to be eligible for casirivimab/imdevimab, bamlanivimab/etesevimab or Sotrovimab

☐ at least 12 years of age and weighing at least 40 kg

☐ COVID-19 positive by PCR or Antigen testing

OR

☐ Post-Exposure Prophylaxis to COVID-19 for those at high risk for progression to severe COVID-19 AND who are not fully vaccinated -or- have an immunocompromising condition. If there is a supply issue, then COVID-19 positive patients will be infused prior to the patients for Post Exposure Prophylaxis patients. (Sotrovimab not indicated for PEP)

☐ Meets all of the following requirements:

- at high risk for progressing to severe COVID-19 and/or hospitalization
- is NOT hospitalized,
- is NOT requiring oxygen therapy due to COVID-19,
- is NOT requiring an increase in baseline oxygen flow rate due to COVID-19 in those on chronic oxygen therapy due to underlying non-COVID-19 related comorbidity

SARS-CoV-2 Specific Monoclonal Antibody CRITERIA FOR USE (continued)

☐ Does not have suspected or proven serious, active bacterial, fungal, viral, or other infection (excluding COVID-19)

☐ **High risk - defined as meeting one or more of the following criteria (select all that apply):**

☐ Body Mass Index (BMI > 25) ☐ Cardiovascular disease ☐ Chronic Kidney Disease
☐ Hypertension ☐ Diabetes ☐ COPD/other chronic respiratory disease ☐ Immunosuppressive Disease
☐ Pregnancy ☐ Medical related technology dependence e.g., gastrostomy)
☐ Receiving immunosuppressive treatment ☐ Sickle cell disease (e.g., gastrostomy)
☐ Age ≥ 65 years
☐ Neurodevelopmental disorders or other conditions that confer medical complexity(e.g., genetic, or metabolic syndrome)

☐ **Patient or caregiver received a copy of the APPROPRIATE mAB INFUSION fact sheet**

- casirivimab/imdevimab fact sheet https://www.fda.gov/media/143893/download,
- bamlanivimab/etesevimab fact sheet at https://www.fda.gov/media/145803/download
- Sotrovimab fact sheet at https://www.fda.gov/media/149533/download
- Remdesivir fact sheet: 1 PATIENT INFORMATION VEKLURY® (VEK-lur-ee) (remdesivir) for injection VEKLURY® (VEK-lur-ee) (remdesivir) injection What is VE
- Patient was informed of risks and benefits of therapy, availability of alternatives and that the drug is an unapproved drug authorized for use under the Emergency Use Authorization, or FDA approved but use is off-label.
- Patients understand they have the option to accept or refuse treatments and, understanding the risks, benefits and alternatives, have agreed to accept treatment with casirivimab/imdevimab or bamlanivimab/etesevimab based on drug availability.

SARS-CoV-2 Specific Monoclonal Antibody DOSING

Pharmacy may dispense casirivimab/imdevimab or bamlanivimab/etesevimab or Sotrovimab based on availability for facility and current EUA guidelines

☐ casirivimab 600 mg & imdevimab 600 mg ☐ bamlanivimab 700 mg & etesevimab 1400 mg ☐ Sotrovimab 500mg

- added to 100 mL 0.9% NaCl IV Infusion Once, Infuse over 31 minutes, use 0.2/0.22 micron in-line filter

If Omicron variant highly suspected and Sotrovimab is not indicated or unavailable:

☐ remdesivir 200mg IV in NS 40mL on ☐ Day 1 followed by remdesivir 100mg IV in NS 60mL on ☐ Day 2 & ☐ Day 3

- Infuse over 30-120 minutes
- **Only use if within 7 days of symptom onset**

☐ **If CKD is present or an eGFR of <30 is suspected, please obtain renal panel prior to infusion**

Post-Infusion:

- **Flush administration set with 0.9% sodium chloride to deliver residual volume.**
- **Leave IV in place for observation period; remove prior to discharge.**
- **Monitor patient for hypersensitivity reaction for a period of 60 minutes following infusion.**
- **Record vital signs immediately following infusion and prior to discharge.**
- **Provide patient with discharge instructions. Send record of treatment to prescriber at fax number as appropriate.**

- **If signs and symptoms of a clinically significant hypersensitivity reaction or anaphylaxis occur, immediately discontinue administration and initiate appropriate medications and/or supportive therapy (see ADVERSE REACTIONS below)**

ADVERSE REACTIONS

MINOR REACTIONS (e.g. nausea, itching, joint pain, rash)	**SEVERE REACTIONS** (e.g. bronchospasm, loss of airway, fainting, severe flushing)
STOP infusion	**CALL A CODE OR RAPID RESPONSE**
diphenhydrAMINE 50 mg IV Push Once	**STOP** infusion
famotidine 20 mg IV Push Once	EPINEPHrine 0.3 mg/0.3 mL SubCutaneous Once
dexaMETHasone 10 mg IV Push Once	Oxygen PRN
Notify Physician	Notify Physician

Prescriber Signature_____ **Date/Time**_____